Medicare Fraud and Abuse

What is Medicare?

Medicare is the nation's largest federal health insurance program, covering nearly 40 million Americans. It is administered by the Centers for Medicare and Medicaid Services (CMS) and pays for health care services for:

- Persons age 65 and over,
- Some people with disabilities under the age of 65, and
- People in end stage renal disease (ESRD) – permanent kidney failure treated with dialysis or a transplant.

Medicare has two parts:

1. **Part A (Medicare Hospital Insurance)** helps pay for inpatient care in hospitals, skilled nursing facilities (nursing homes) or psychiatric hospitals; and for hospice and some home health care services.

2. **Part B (Medicare Medical Insurance)** helps pay for doctors' services, outpatient hospital care, and some other medical services not covered by Part A, such as physical and occupational therapy and some home health care. Part B also pays for durable medical equipment (DME) and supplies when they are "medically necessary."

What are "medically necessary" services and supplies?

Medically necessary services, durable medical equipment (DME) and supplies:

- Are appropriate and required to diagnose or treat a medical condition,
- Meet the standards of good medical practice in the local area, and
- Are not mainly for the convenience of the Medicare beneficiary or the prescribing physician.

What is health care fraud?

Fraud is defined as obtaining or attempting to obtain services or payments by dishonest means – with **INTENT**, **KNOWLEDGE** and **WILLINGNESS**.

What is Medicare fraud?

Medicare fraud is the **intentional deception or misrepresentation** of services provided to Medicare beneficiaries that results in unnecessary cost to the program, improper payments to providers, or overpayments.

Medicare fraud involves purposely billing Medicare for services that were never provided or received, or billing for a service that has a higher reimbursement rate than the service actually provided.

What is Medicare abuse?

Unlike Medicare fraud, which involves an intentional deception or misrepresentation, Medicare abuse occurs when physicians, providers, or suppliers mistakenly bill for items or services that should not be paid for by Medicare because they:

- Are inconsistent with accepted sound medical practices,
- Fail to meet professionally recognized standards of care, or
- Are medically unnecessary.

Examples of Medicare fraud:

- Billing Medicare for services never performed or medical equipment or supplies not ordered
- Billlling Medicare for services or equipment that are different from what was provided
- **DOUBLE BILLING** – Charging more than once for the same service

- Billing Medicare for home medical equipment after it has been returned

- Continuing to provide medical services or supplies when they are no longer necessary

- **UPCODING** – billing for a more expensive or Medicare covered item when a less expensive, non-covered item was provided. Altering claim forms to obtain a higher payment amount. Misuse of the standardized system of numerical codes for patient services to increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided (**for example**, charging for a surgical procedure in place of applying a bandage to a wound).

- **UNBUNDLING** – billing related services separately to charge a higher amount than if they are combined and billed as one service or group of services (**for example**, billing laboratory tests separately to charge a higher amount than if they are combined and billed as a panel of tests).

- Billing non-covered services as covered services (**for example**, billing for a case of the flu instead of a routine physical examination)

- Completion of a Certificate of Medical Necessity (CMN) by a provider, instead of the prescribing physician

- Completion of CMNs by a provider for patients not professionally known or treated by that provider

- Involvement of doctors in falsification of CMNs

- Surgical dressing scams (**for example**, repetitive delivery of dressings on a schedule, regardless of medical need; billing for dressings that are contraindicated; and provision of wound coverings not proportional to the size of a wound or the number of wounds)

- Using another person's Medicare card to get medical care, supplies, or equipment

- Soliciting, offering or receiving enticements, bribes or rebates (**for example**, money, free items for beneficiaries, or kickbacks for patient referrals to physicians, providers, nursing homes, etc.)

What is a kickback?

A kickback is an arrangement between two parties which involves an offer **to pay for** Medicare business. Kickbacks generate extra business for the participants and unneeded services for the patients. They also drain scarce tax dollars. Health care providers engaging in kickback activities are subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

Kickback examples:

- Providing hospitals or nursing homes with discharge planners, home care coordinators, or home care liaisons in order to induce referrals

- Paying a fee to a physician for each patient care plan certified by the physician on behalf of the home health agency

- Providing **"free"** patient services, such as 24-hour nursing coverage, to board and care facilities in return for home health referrals

- Paying a fee to a board and care operator or employee for each resident referred to a home health agency. This is, in effect, **buying of patients**.

- Offering free services to beneficiaries, including meals and transportation, if they agree to switch home health providers

- Paying beneficiaries $50 each time they receive **"treatment"** at a clinic

In these cases, the **"free"** services and business inducements are typically misrepresented so that Medicare pays for them as though they were legitimate covered services. Often some other program also pays for these services.

How to recognize Medicare fraud:

Be suspicious if a provider tells you that:

- The equipment, service or test is free. It won't cost you anything. **MEDICARE DOES NOT PROVIDE ANYTHING FOR FREE!** People on Medicare pay with higher premiums. All of us pay through tax increases.
- Although the equipment, service or test is free, he only needs your Medicare number **for his records** *(NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is not cost to the person with Medicare).*
- Medicare wants you to have the item or service.
- He knows how to get Medicare to pay for items or services, even if they are not usually covered.
- The more tests that they provide, the cheaper they are.

Be suspicious of providers who:

- Claim that they represent Medicare.
- Use telemarketing and door-to-door selling as marketing tools.
- Advertise **"free"** consultations to people on Medicare or offer **"free"** testing or screening in exchange for your Medicare card number, just for their records.
- Use pressure or scare tactics to sell you high-priced medical services or diagnostic tests.
- Routinely waive co-payments or deductibles on any services, other than those previously mentioned, without either checking your ability to pay or verifying your financial need.
- Charge co-payments on clinical laboratory tests, and on Medicare covered preventive services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.

DO'S and DON'TS – *Tips to help prevent Medicare fraud:*

DO **Protect your Medicare Health Insurance Claim Number** (on your Medicare card). Don't ever give it out except to your physician or other Medicare provider.

DO **Remember that nothing is ever "free."** Don't accept offers of money or gifts for free medical care.

DO **Ask questions!** You have a RIGHT to know everything about your medical care, including the costs billed to Medicare.

DO Educate yourself about Medicare. Know your rights and know what a provider can and cannot bill to Medicare.

DO Be cautious of any provider who maintains he has been endorsed by the federal government.

DON'T accept medical supplies from a door-to-door salesman.

DO be wary of the "We know how to bill Medicare" scam. Avoid providers who tell you that the item or service is not usually covered, but they know how to bill Medicare.

DO always count your pills to be sure you have received the full amount.

DON'T allow anyone, except appropriate medical professionals, to review your medical records or recommend services.

DON'T contact your physician to request a service that you do not need. Don't let anyone persuade you to see a doctor for care or services you don't need.

DON'T be influenced by media advertising concerning your health. Television and radio ads are intended to raise money for someone. They do not have your best interest at heart.

DO review your Medicare payment notice (EOMB or MSN)♠ for errors. The payment notice shows what services or supplies were billed to Medicare, what Medicare paid, and what you owe. Make sure Medicare was not billed for health care services or medical supplies and equipment you did not receive. **Always inventory medical supplies and check against your EOMB or MSN.**

DO Report suspected instances of fraud **(See How to Report Medicare Fraud)**.

What are the consequences of Medicare fraud and abuse?

Most Medicare payment errors are simple mistakes and are not the result of physicians, providers, or suppliers trying to take advantage of the Medicare system. The vast majority of physicians, providers, and suppliers who serve Medicare beneficiaries provide high quality care to their patients and bill the program correctly only for the services they have provided.

However, there are a few individuals who are intent on abusing or defrauding Medicare, cheating the program (and in some cases the people with Medicare who are liable for co-payments) out of millions of dollars annually.

Medicare fraud drains a lot of money from the Medicare program every year. Medicare is taking strong action to combat fraud and abuse of the system in key areas.

The effort to prevent and detect fraud is a cooperative one that involves:

- The Centers for Medicare and Medicaid Services (CMS),
- Providers of Medicare services, including physicians, providers, and suppliers,
- State and Federal Agencies such as the Department of Health and Human Services Office of the Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ), and

➔**MEDICARE BENEFICIARIES** ←

♠ EOMB = Explanation of Medicare Benefits; MSN = Medicare Summary Notice

Medicare fraud is not:

- **An honest mistake by the provider.** Everyone makes mistakes and clerical errors occur all the time. With staff turnover, it is difficult for an office to retain someone who knows how to input medical codes correctly.

- A bill for more time than the patient thinks was spent with the doctor. Since doctors bill in blocks of time, it doesn't matter if they see a patient for 5 minutes or fifteen. They bill for the full block of time allowed.

- Situations where "**you just know"** something is wrong. A gut feeling that something is wrong cannot be proven without documentation.

- Hospital bills that just seem **"too high."** Providers are contracted at specific amounts for specific services and/or equipment and bill CMS according to those contracted amounts.

- Charges on the Medicare statement for doctors such as anesthesiologists, radiologists, etc. that the beneficiary doesn't remember seeing. This is not uncommon because these doctors provide specialized services behind the scene or bill separately from the primary care doctor.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

To Report Suspected Medicare Fraud

Call Toll-free 1-800-726-2916

Or Write to Address Below

DHHS – Division of Aging & Adult Services (501) 682-8504
700 Main Street, P.O. Box 1437, Slot S530 **1-866-726-2916**
Little Rock, AR 72201-1437 *sharon.marcum@arkansas.gov*